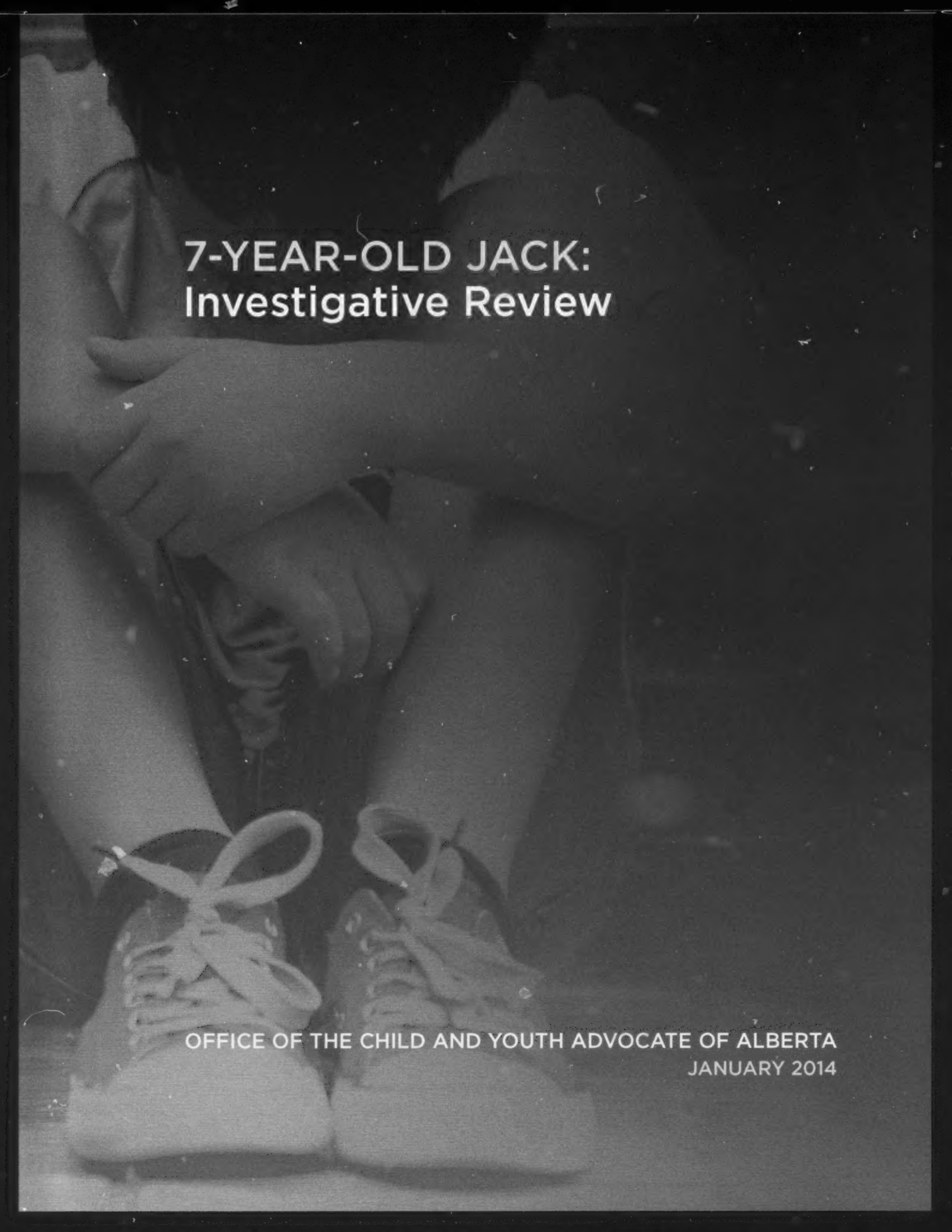




7-YEAR-OLD JACK: Investigative Review

OFFICE OF THE CHILD AND YOUTH ADVOCATE OF ALBERTA
JANUARY 2014

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say

**specialized advocacy
for youngPeople**

Under my authority and duty as set out in the *Child and Youth Advocate Act*, I am providing the following Investigative Review concerning the passing of a young person who was, at the time, receiving services from the Government of Alberta. Consistent with section 15 of the Act, the purpose of this report is to learn from this tragic event and recommend ways of improving Alberta's child intervention system.

While this is a public report, my office has taken great care to protect the privacy of the family members of the young person involved. The names used in this report are pseudonyms and the report refrains from disclosing information that could be used to identify the young person or his family.

Accordingly, I would request that readers and interested parties, including the media respect this privacy and not focus on identifying the individuals and locations involved in this matter.

This review is about a boy who lost his life in a drowning accident. But more than that, it is a review about a seven year old boy who lived a hard life. From birth, he was impacted by his parent's substance misuse, and life with his parents was characterized by an unstable and transient lifestyle. When he was brought into care, he was placed in a stable foster home, but struggled with relationships and mixed messages about his future. Attempts were made to ensure permanence and certainty for him. At the time of his passing, however, after being in care for almost two and a half years, there was no certainty in his placement, no certainty in his relationships and no certainty in his future. For those children who are in care and live with these uncertainties, we need to do better.

[Original signed by Del Graff]

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EXECUTIVE SUMMARY

Alberta's Office of the Child and Youth Advocate (the "Advocate") is an independent office reporting directly to the Legislature of Alberta, deriving its authority from the *Child and Youth Advocate Act*. Section 9(2)(d) of the *Act* states that, "...the Advocate may investigate systemic issues arising from a serious injury to or the death of a child who was receiving a designated service at the time of the injury or death if, in the opinion of the Advocate, the investigation is warranted or in the public interest".

In 2012, Jack (not his real name), a seven-year-old child was taken to a local public swimming pool along with two other residents of his group home. After being left unsupervised for a very short time, Jack was found unresponsive near the pool's deep end and was pronounced dead shortly after his arrival at hospital. The Office of the Medical Examiner determined the cause of death to be drowning. At the time of his death, Jack was the subject of a Temporary Guardianship Order.

In November 2012, the Child and Youth Advocate advised the Minister of Human Services that an Investigative Review into the circumstances of Jack's death would be conducted.

In addition to the Advocate's Investigative Review, three separate independent reviews were conducted in relation to Jack's death. These included:

- A review by the contracted agency that operated the group home in which Jack resided at the time of his death;
- A review by the Child and Family Services Authority (CFSA) in relation to the contracted agency's operation; and
- A review by the municipality which owned and operated the public swimming pool in which Jack was found unresponsive.

Jack was described by many as an intelligent, polite and socially mature boy. He liked playing sports and learning new things. Jack had six older half-siblings, all of whom were raised by members of their extended family. When Jack was four years old, he and his parents moved from the Maritimes to Alberta. In Alberta they lived a transient lifestyle, moving from hotel to hotel. Both of Jack's parents struggled with substance addictions, regularly using marijuana and cocaine. Before coming into care, Jack had little structure or routine. He did not know from day to day whether his basic needs would be met.

Jack was five years old when he came into care and was placed with a foster family where there were seven other children. He had to adjust to a way of life that was much more structured than he was accustomed to. He lived with this family for 28 months. During this time, his parents continued to struggle with their addictions, but they had ongoing visits with Jack. His parents frequently made unfulfilled promises to him that he would soon come home to live with them. This caused Jack a great deal of confusion, anger and sadness.

With an extensive transition plan, Jack then moved to the home of an approved single adoptive parent who agreed to be a foster parent for Jack with the intention of adopting him should a Permanent Guardianship Order be granted. After three turbulent months in this placement, he was moved to a group home in a transition that did not go well and appeared to involve little planning. Jack lived at the group home until he passed away, eleven days later.

Within hours of Jack's death, a donation professional contacted Human Services requesting that Jack's tissues be donated. During a very short window in which a decision had to be made, unsuccessful attempts were made to locate Jack's parents. The request to donate Jack's tissues was approved by senior child intervention officials within two hours of the request being made.

The information gathered through the investigative process revealed a number of key issues related to practices and processes in the child intervention system:

- **Supporting Key Relationships for Children in Care.** During his journey through the child intervention system, Jack experienced grief and confusion over the cumulative losses of his relationships. Compounding these losses was Jack's growing distress over the gulf between his parents' promises that he would be returning home, and the reality of his situation. Placement moves are often inevitable and occur for a number of reasons, but how these transitions occur is important for the health and well-being of a child. When bringing a child into care and transitioning the child between placements, the child intervention system needs to support continuity of connections with parents, caregivers and other key individuals. This is critical to building resiliency in the child and supporting the achievement of permanency.
- **Court Delays for Children in Temporary Care.** Jack had been in care for eight months when a decision was made to apply for a Permanent Guardianship Order. Jack's parents were not in agreement with the application, resulting in the need to schedule a hearing. The hearing was postponed three times, which drew out the court process for two years. Two of the three adjournments were due to delays on the part of Jack's parents. The Advocate is discouraged by the court delays and the impact they had on establishing permanency for Jack. Children need to have some degree of certainty and need to know what the future might hold for them. Jack is not the only child who has experienced this situation; it is a situation that must be addressed.

- **Designing and Evaluating Interventions in a Team Context.** More could have been done to bring together the key people in Jack's life and make decisions through a more holistic approach. Instead, individuals who had influential relationships with Jack appeared to act in silos and information was not adequately shared. Had a more holistic approach been taken, the supports and services provided to Jack may have produced better outcomes for him. It is important that key people such as foster parents, birth parents, therapists and teachers can collectively exchange information toward ensuring that planning for a child is current and relevant. Wherever appropriate, the child needs to participate in these meetings.
- **Ensuring Lessons are Learned Province-wide.** When concerns are raised about a placement, or when a serious incident occurs regarding a child in care, the service delivery system where the incident occurred, may conduct a placement investigation or review. In this case, the CFSA conducted a review and made recommendations; these were recorded in the central, electronic database system belonging to Human Services. However, there does not appear to be any centralized, formal process in place for analyzing the results of this and other placement reviews and disseminating the lessons from these reviews on a province-wide basis. This presents a significant opportunity for making system-wide improvements, as the results of a placement review in one service delivery system would no doubt have relevance in other areas of the province.
- **Decision-Making After a Child in Temporary Care Passes Away.** After Jack passed away, the CFSA gave approval for his tissues to be donated. This decision was made by senior child intervention officials. The Advocate found that child intervention policy is unclear regarding the decision-making authority for children who pass away while in temporary care. Furthermore, there are questions about what parents are told when their children are brought into the care of government, particularly in relation to decision-making.

To address these issues and to help improve the effectiveness of Alberta's child intervention system, the Advocate makes the following five recommendations:

1. The Ministry of Human Services should ensure the preservation or resolution of relationships are at the foundation of permanency planning for children:
 - Children need to be involved - at a level appropriate to their understanding - in envisioning how their significant relationships will look in their future. Attention should be given to grief and loss interventions where relationships are lost or ambiguous; and,
 - Transitions between parental care and placements within the system need to be deliberate and focused on a child's need for consistent relationships.

2. The Ministry of Human Services in collaboration with the Ministry of Justice and Solicitor General should undertake a review of court delays for children in temporary care:
 - Identify the number of children for whom court delays have impacted permanency;
 - Identify the barriers that are causing the court delays;
 - Establish a plan to resolve this issue; and,
 - Report on progress.
3. The Ministry of Human Services needs to reinforce compliance to existing policy regarding regular case-conferencing with all stakeholders and service providers, ensuring that children are involved whenever possible.
4. The results of service delivery placement investigations should be better coordinated to ensure that:
 - Recommendations resulting from these investigations are documented and accounted for in the electronic database to ensure their resolution;
 - Results of placement investigations are centrally analyzed in order to identify key learnings that could enhance the strength of the overall system; and,
 - The learnings identified from service delivery investigations are actively disseminated province-wide, with the goal of enhancing the safety and well-being of children in care.
5. The Ministry of Human Services should:
 - (A) Review, clarify and communicate policy regarding the decision-making authority of the Director when a child in temporary care passes away. Including clear policy direction for decisions related to tissue donation; and,
 - (B) Review case practice in relation to what parents are told when their child is in temporary care, specifically the decision-making that might occur in the parents' absence. Policy should be implemented to ensure consistent application across the province.

INTRODUCTION

The Office of the Child and Youth Advocate

Alberta's Office of the Child and Youth Advocate (the "Advocate") is an independent office reporting directly to the Legislature of Alberta. The Advocate derives its authority from the *Child and Youth Advocate Act*¹, which came into force on April 1, 2012.

The role of the Advocate is to represent the rights, interests and viewpoints of children receiving services through the *Child, Youth and Family Enhancement Act*² (*Enhancement Act*), the *Protection of Sexually Exploited Children Act*³ (*PSECA*), or from the Youth Criminal Justice System.

Investigative Reviews

Section 9(2)(d) of the *Child and Youth Advocate Act* provides the Advocate with the authority to conduct investigative reviews and states, "...the Advocate may investigate systemic issues arising from a serious injury to or the death of a child who was receiving a designated service at the time of the injury or death if, in the opinion of the Advocate, the investigation is warranted or in the public interest".

Upon completion of an investigation under this section, the Advocate releases a public Investigative Review report. The purpose of an Investigative Review is to make findings regarding the services that were provided to the young person, and make recommendations that may help prevent similar incidents from occurring in the future.

An Investigative Review does not assign legal responsibilities, nor does it supplant or abrogate other processes that may occur, such as investigations or prosecutions under the *Criminal Code of Canada*. The intent of an Investigative Review is not to find fault with specific individuals, but to identify key issues along with meaningful recommendations which:

- are prepared in such a way that they address systemic issue(s); and
- specific enough that progress made on recommendations can be evaluated; yet,
- not so prescriptive to direct the practice of Alberta government ministries.

¹ *Child and Youth Advocate Act*, S.A. 2011, c. C-11.5.

² *Child, Youth and Family Enhancement Act*, RSA 2000, c. C-12.

³ *Protection of Sexually Exploited Children Act*, RSA, c. P-30.3.

It is expected that ministries will take careful consideration of the recommendations, and plan and manage their implementation along with existing service responsibilities. The Advocate provides an external review and advocates for system improvements that will help enhance the overall safety and well-being of children who are receiving designated services. Fundamentally, an Investigative Review is about learning lessons, rather than assigning blame.

About This Review

In the summer of 2012, seven-year-old Jack (not his real name)⁴ was found unresponsive in a public swimming pool. All attempts at resuscitation were unsuccessful. The Office of the Medical Examiner determined the cause of death to be drowning. At the time of his death, Jack was the subject of a Temporary Guardianship Order⁵ (TGO) and was placed in a group home.

The Advocate thoroughly reviewed file information provided by the Ministry of Human Services. Through this, a preliminary investigative report was completed, which identified a number of potential systemic issues that would benefit from an Investigative Review. In November 2012, the Child and Youth Advocate advised the Minister of Human Services that an Investigative Review into the circumstances of Jack's death would be conducted.

Terms of Reference for the Investigative Review were established, a copy of which is provided in Appendix 1. An investigative team was assigned to gather information and conduct an analysis of Jack's circumstances through a review of relevant documentation, interviews, and research. A number of individuals were identified as persons who would be able to provide insight into Jack's circumstances.

A preliminary report was completed and presented to a committee of subject matter experts whose purpose was to provide advice related to findings and recommendations. The list of committee members is provided in Appendix 2. Committee membership was determined based on members' experience in permanency planning, parenting capacity, investigative death reviews, and medical ethics.

⁴ All names used throughout this Investigative Review are pseudonyms. Section 15(3) of the *Child and Youth Advocate Act* states that a report must not disclose the name of, or any identifying information about, the child to whom the investigation relates or a parent or guardian of the child.

⁵ Under a Temporary Guardianship Order, the court awards custody and guardianship of the child to the Director for a specified period of time. The child is in the care of the Director and is placed in an approved placement. The Director shares guardianship with the parent/legal guardian of the child.

In addition to the Advocate's Investigative Review, three separate independent reviews by other review bodies were conducted in relation to Jack's death. These included:

- A review by the contracted agency that operated the group home in which Jack resided at the time of his death;
- A review by the Child and Family Services Authority in relation to the contracted agency's operation; and
- A review by the municipality which owned and operated the public swimming pool in which Jack was found unresponsive.

All three of these reviews recommended changes to policies, operations and strategies related to improving accountability, safety practices, standards, prevention and awareness. A summary of the recommendations made by these separate reviews is contained in Appendix 3.

BACKGROUND

About Jack

Jack was born in the Maritimes. He had cocaine in his system and required treatment for neonatal abstinence syndrome⁶. He remained in the care of his mother and father until he was five years old. Jack was described by his caregivers as intelligent, polite and socially mature for his age. He had a slight build, brown hair and wore glasses. Jack liked playing sports and learning new things.

Jack was academically advanced; however, his lack of interaction with other children left him delayed when it came to interpersonal skills with peers. When in the presence of other children, Jack could be destructive, angry, oppositional and anxious in unfamiliar situations.

After being brought into care, Jack deeply missed living with his parents, Joe and Mary (not their real names), and was frustrated and anxious because they were not doing what was required to enable him to return to their care. Throughout the investigative review process it was evident that the significant adult in Jack's life was his father.

Jack had three placements while in the care of child intervention services. At the time of his passing, Jack was the subject of a Temporary Guardianship Order (TGO) and was living in a group home.

About Jack's Family

Jack had six older half-siblings. All of his siblings were raised by members of their extended family due to concerns related to neglect, family violence and parental drug use. In addition, there were allegations that Jack's mother, Mary, may have been involved in prostitution and she was known to panhandle to raise money. His father, Joe, was incarcerated for periods of time on both drug-related charges and driving offences.

When he was four years old, Jack and his parents moved to Alberta where they lived a transient lifestyle, moving from hotel to hotel. Joe found occasional construction jobs to support the family, but they relied heavily on Mary's panhandling and government assistance. Joe and Mary struggled with substance addictions, regularly using marijuana and cocaine. Mary was also known to abuse alcohol.

⁶ Neonatal abstinence syndrome (NAS) is a group of problems that occur in a newborn who was exposed to addictive illegal or prescription drugs while in the mother's womb.

HISTORY OF INVOLVEMENT WITH CHILD INTERVENTION SERVICES

Services Provided in Jack's Early Years

When Jack was one year old and still living in the Maritimes, a Supervision Order⁷ was obtained due to his parents' limited support system, reported drug use, and inconsistent follow through with medical appointments for Jack. Child protective services there remained involved for approximately 28 months. The involvement ended when Joe and Mary followed through with necessary medical appointments.

There was no further involvement with the family for about one year.

Services Provided to Jack at 4 Years Old

Jack first came to the attention of child intervention services in Alberta when he was four years old. A complaint was received that Mary was panhandling while Jack was with her. It was reported that she would approach strangers and ask for money so that she could take care of Jack and pay the rent. An intervention worker responded to the hotel room where the family was staying, and found Jack to be in good health. The room was clean and there appeared to be adequate food, clothing and toys for Jack. The matter was closed at screening as there were no protection concerns identified.

Within three months, similar concerns were received and the matter was assigned for assessment. The assessor found Jack to be bright and articulate for his age; he appeared to be in good health and well cared for. Although, Joe and Mary admitted to occasional marijuana and cocaine use, they stated that they did not use drugs in front of their son and there was no visible evidence of drug use. The matter was transferred to a community office for further assessment.

Throughout the detailed assessment phase, numerous concerns were received from the community about Mary's panhandling. Joe was arrested on outstanding warrants related to driving offences. Mary agreed to access community resources and social assistance. She disclosed that she had been using "crack"⁸ cocaine once per week but was committed to quitting. She agreed to provide daily updates to the assessor ("Assessor One"), attend regular drug tests, and complete a drug and alcohol assessment. Assessor One arranged for an in-home support worker to help the parents locate a permanent residence (i.e., not a hotel room); access community and drug rehabilitation resources; and, enhance their parenting skills. During this period Mary attended two drug screenings, with both results testing positive for marijuana.

⁷ Obtained from the Department of Social Development in the Maritimes.

⁸ Crack or crack cocaine is a form of cocaine that is usually inhaled as smoke.

To ensure Jack's safety, Assessor One applied for a Supervision Order⁹. The application was adjourned three times: twice to allow Joe and Mary to retain legal representation, and once on the direction from the judge to work out the disputed terms of the Order.

At this time, a new assessor ("Assessor Two") became involved. Although there were ongoing concerns about panhandling and drug abuse by Jack's parents, a decision was made, in consultation with the supervisor, to withdraw the Application for a Supervision Order. This decision was based on regular unannounced home visits by Assessor Two, continued financial support from social assistance and no visible signs of either parent using alcohol or drugs. The interaction between Jack and his parents was observed to be very positive. However, it was also noted that Joe and Mary were not attending random drug screenings. The intervention file was closed.

Approximately one month later, child intervention services received a report of similar concerns related to panhandling and drug abuse by Jack's parents. Joe and Mary told the assessor that they had separated because their relationship could not take the "on-going harassment from the beat officers (police) and interference from child intervention workers". Mary was taking Jack back to the Maritimes and Joe was moving to another province. The file was closed and child intervention authorities in the Maritimes were notified.

Unknown to child intervention services, Mary and Jack returned to Alberta and reunited with Joe two months later.

Services Provided to Jack at 5 Years Old

Shortly after their return to Alberta, child intervention services was notified that Jack's family had been evicted from the hotel in which they had been residing, and their social assistance was terminated for non-compliance. Initial attempts to locate the family were not successful and an alert was placed on the information system, indicating that an urgent response was required should the family come to the attention of child intervention services.

Approximately one month later, the family was located when complaints were received that Joe and Mary were panhandling with their son present, and that they were using drugs. Joe was arrested on warrants for driving offences. A subsequent search of his belongings revealed drug paraphernalia, and he admitted to using crack cocaine almost daily. Mary denied using drugs but admitted that she was aware that Joe used drugs. Jack appeared to be healthy and presented as well-adjusted and polite. Mary was provided with emergency funding and Jack remained in her care. The matter was forwarded for an urgent assessment due to the family's transiency and chronic inability

⁹ A Supervision Order is sought when mandatory supervision of a child and a person living with them is necessary to adequately protect the survival, security and development of the child. Intervention services are provided to the child and family/legal guardian through a court order. Guardianship and custody of the child rests with the family/legal guardian.

to provide the necessities of life for Jack. The following day after further assessment, an Apprehension Order¹⁰ was obtained and Jack was placed in foster care with Mr. and Mrs. Smith (not their real names).

Jack initially experienced difficulties in his foster care placement. Mr. and Mrs. Smith reported that Jack was frightened, emotionally fragile and anxious in his new environment. He did not sleep well and was not eating much. They noted that Jack knew the name of every candy bar but could not name vegetables which led them to believe that he had not been eating nutritious meals while in the care of his parents.

Regular visits between Jack and Mary (and Joe, after his release from jail) occurred at the assessor's office. Mr. and Mrs. Smith felt that these visits were stressful on Jack, and stated that he often became physically ill before or after a visit.

Jack gradually adjusted to his placement. The Smith's reported that he was polite and socially mature with adults, but destructive and sometimes manipulative with his peers. In addition, they stated that he was intelligent and had been taught reading fundamentals. Despite this, Jack was held back from kindergarten to allow his anxiety to lessen as he adjusted to his placement. Jack was diagnosed by a physician as being underweight and malnourished. He required ongoing medical, dental and optical treatment. Later, the physician also referred him for a mental health assessment.

Mary admitted to the assessor that she had been using crack cocaine regularly and had been panhandling every day to pay for the hotel room. However, she denied ever having taken Jack with her. Mary told the assessor that she wanted to get "cleaned up", get a job and get Jack back. Although she admitted to having a drug problem, Mary later told the assessor that she did not require treatment.

The assessor applied for a Temporary Guardianship Order (TGO) because it was determined that Jack's basic care and safety needs could not be met until his parents achieved a significant period of sobriety.

The file was transferred to a caseworker ("Caseworker One"). Following a mediator-facilitated meeting, Joe and Mary consented to a three month TGO.

Jack's parents struggled with complying with the terms of the Order. They failed to attend drug screenings and did not complete the recommendations from their alcohol and drug assessments. The family support worker reported that they missed numerous appointments and were not consistent in attending parenting courses. They attended regular visits with Jack, which were viewed as positive. It was apparent that their interactions were warm and caring. However, Joe and Mary told Jack that he would be coming home soon which caused him a great deal of confusion and stress.

¹⁰ An Apprehension Order is sought when a child cannot be adequately protected in their family setting. The court grants the Director temporary custody and guardianship of the child. Guardianship is shared with child's parent/legal guardian. The child is placed in an approved placement.

The TGO was extended for six months because Joe and Mary did not comply with the terms of the Order.

Caseworker One subsequently applied for a Permanent Guardianship Order¹¹ (PGO) because Joe and Mary were not dealing with their addiction issues, had been inconsistent with maintaining contact with support services; and there were concerns that Mary had large sums of unexplained money. Jack had been in care for 237 days¹².

Services Provided to Jack at 6 Years Old

Joe and Mary did not consent to the PGO Application resulting in a hearing being scheduled. The hearing was postponed for nine months due to two court adjournments – the first adjournment was agreed to by all parties as more information was needed before the hearing could proceed; the second adjournment was due to double-booking within the court system and the hearing being bumped. Jack had now been in care for 559 days (just over 18 months).

Jack moved into grade one. Mr. and Mrs. Smith and his teacher had concerns about his behavior at school. Although he was well liked by other students and described as a leader who could be the first to do good things, Jack was also the first to get into trouble. Jack's teacher told Caseworker One that Jack was not adjusting to class rules and did not listen in class. It took several months for Jack to adjust. Gradually, he was able to sit and do his schoolwork.

Mr. and Mrs. Smith were concerned about how Jack was settling into their family. They expressed to the caseworker that they felt that Jack was "not attaching" and that he instigated conflict with his foster siblings. Jack was keenly aware of the conditions his parents were required to satisfy before he could go home, and he appeared to be frustrated and angry with his parents for not satisfying these conditions. Jack told Mr. and Mrs. Smith that his parents' broken promises were confusing him; he told his caseworker that it made him sad.

At the request of his foster parents, Jack's pediatrician made a referral for Jack to see a mental health therapist. The therapist described Jack as emotionally detached and was concerned that he was displaying symptoms of an attachment disorder¹³. She

¹¹ Under a Permanent Guardianship Order, the court awards guardianship of the child to the Director on a permanent basis. The child is in the care of the Director and remains in an approved placement. The guardianship of any former guardian is terminated and the Director is made the sole legal guardian of the child.

¹² The *Child, Youth and Family Enhancement Act 33(2)(b)* indicates that a child 6 years of age or older shall not remain in the temporary care of the Director for more than 12 months. Section 33(3) allows for one extension of six months if there are good and sufficient reasons to do so, or it is anticipated that the child may return to his/her guardians in that time.

¹³ Lack of or incompletely formed preferred attachments to caregiving adults. *The Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, American Psychiatric Association, 2013.

recommended play therapy which she could provide through Mental Health Services and which did not require a formal contract with child intervention services. Jack attended play therapy with her for 15 months. During this time, the caseworker had occasional phone contact with the therapist; but, most of the communication was via Mr. and Mrs. Smith.

Jack was referred to a child and adolescent psychiatrist, at the request of the Smith's, to determine if he had an attachment disorder. The psychiatrist felt there was not enough information to support a diagnosis of Attachment Disorder. However, he noted that Jack's general level of anxiety was quite elevated. Jack told the psychiatrist that he felt nobody cared about him and nobody liked him. Jack also expressed worry about his parents, and said that he wanted to live with them. The psychiatrist recommended that Jack continue in therapy to work on his anxiety and social skills.

A psychological/parenting assessment completed on Joe and Mary recommended that Jack not be returned to their care; that they continue to be involved in his life, but only with appropriate supervision and as they met required goals. In his interview, Jack told the psychologist that he was living with his foster parents because, "my mom wasn't doing the right things".

During this time, Joe and Mary missed all of their scheduled drug screenings. They also cancelled or missed a number of appointments with the family support worker. When they did meet, they were uncooperative or confrontational. Joe and Mary told Caseworker One that they no longer wanted the court-ordered support worker in their home. Mary requested support to attend a residential treatment program. Numerous attempts were made by the caseworker to support the request, but Mary did not follow through with treatment.

Jack had supervised visits with his parents twice a week. Joe and Mary were affectionate, warm and caring. They had moved into a new residence and had purchased all new furniture, including a bunk bed for Jack's bedroom. They also purchased a trampoline and pool for the backyard. They kept telling Jack that he was coming home soon. However, Jack told his foster father that he thought he would be going to a "forever home"¹⁴ because his parents had not done what they were supposed to do.

A new caseworker ("Caseworker Two") was assigned when Caseworker One moved to different position. It was around the same time that a new family support worker was also assigned as Joe and Mary expressed dislike for the support worker they had been working with.

¹⁴ It appears that the terminology, "forever home" is one used by the foster parents and the caseworker when talking to Jack about permanency planning.

Services Provided to Jack at 7 Years Old

Joe and Mary were challenged by the caseworker about why they were not attending drug screenings. Mary informed Caseworker Two that she required transportation and that the previous caseworker would not provide transportation. Both parents admitted to using alcohol and denied using drugs. They later attended a drug screening, their first in two years, and both tested positive for marijuana and cocaine.

Joe and Mary subsequently separated and Mary became involved in a new relationship. Separate visits with Jack were established and these visits no longer occurred at the residence. The family support worker observed changes in Joe's behavior, including positive and genuine concern for the welfare of his son. However, Joe was not attending drug screenings. There was some discussion with Joe about what he would need to do to have Jack returned to his care. He would have to change the locks at his home and keep Mary out, only allowing her to have supervised contact with their son and he would have to abstain from drug and alcohol use.

Mary began missing her scheduled visits with Jack and when she attended, she often left early. Mary did not attend any visits for two months which had a negative impact on Jack. He was upset and worried about his mother's absences. Jack told Caseworker Two that he was mad and sad that his mother missed so many visits.

Mr. and Mrs. Smith voiced concern to the caseworker about the lack of a permanency plan for Jack. They were not in a position to provide a permanent home for him. Some placements with his extended family had been explored but nothing had worked out.

Jack's grade two teacher expressed concern about his increasingly aggressive behavior in school. This included threatening another student with a pencil, swearing at other children and getting frustrated or angry very quickly. The teacher noted that Jack's behaviors were consistently bad the day following parental visits.

Following the nine month delay the scheduled PGO hearing did not proceed because Mary did not attend court and Joe fired his lawyer. By this time, Jack had been in care for 729 days (almost two years). This resulted in another eight month adjournment.

Caseworker Two explored alternative permanent placements for Jack outside of the extended family. An approved single adoptive parent, Ms. Alexander (not her real name), was identified as a possible option. She was approached and agreed to become a foster home for Jack with the intention that she would adopt him should the PGO be granted. This was believed to be a good permanency plan for Jack.

An extensive transition plan was developed among the Smiths, Ms. Alexander, Caseworker Two, the foster care worker and Jack. Jack was described as excited about the upcoming move. His pre-placement visits with Ms. Alexander and her son, Sam (not his real name), went well and no negative behaviors or concerns were noted. Mr. Smith

told Jack that there were "no promises, no guarantees, but probably this is your forever home". After living with the Smiths for 28 months, Jack was moved to his new placement.

Joe and Mary were informed of Jack's move to the permanent placement with Ms. Alexander. Joe appeared to understand why Jack was being moved and was not opposed. Mary was described as depressed when she was told; but, by this time she was using drugs and alcohol heavily, not attending visits regularly and was difficult to contact.

Caseworker Two noted that Jack's first two weeks in the Alexander home went very well. He appeared to adapt well to his surroundings. He enjoyed having an "older brother". Ms. Alexander felt that Jack was connecting well with her family, but his behavior in school remained an ongoing concern.

Within three weeks of the new placement, Ms. Alexander began reporting disturbing behaviors in her home. Jack would go on "rampages" and destroy his room. He also developed testing behaviors, refusing to take direction or just being silly in order to provoke a reaction. Her son, Sam, eventually avoided all contact with Jack and would retreat to his room when Jack got angry.

Jack's behavior escalated and he became physically aggressive with Ms. Alexander and Sam. She was overwhelmed with Jack's behavior. He would not tell her why he was so angry, and would only say that he was "mad and sad".

Due to the volatility in the home, the caseworker discussed the situation with the supervisor and manager who were also concerned as the situation in the home continued to deteriorate. Caseworker Two began to explore alternate placement options for Jack. One-to-one workers were placed in the home to assist when required. Jack had to be restrained on a number of occasions due to his aggressive and violent outbursts.

Given the significant concerns about Jack's behaviors, a decision was made to discontinue his involvement with the mental health therapist and engage a behavioral therapist who could work with the family to develop strategies to deal with his behaviors. While there were some successes, the strategies largely appeared to have little effect. The Smith's, who occasionally provided respite, told Caseworker Two that they did not witness the same behaviors when Jack was with them. Jack did not know why he was being destructive. When asked, he would only say that he was sad.

Jack developed behaviors that placed him and others in danger. For example, while in Ms. Alexander's vehicle, if he became agitated he would unbuckle his seat belt and unlock the passenger door. When this occurred, Ms. Alexander would pull over, stop the vehicle, get out and walk with Jack until he calmed down. This behavior was witnessed by Caseworker Two on a very busy highway, resulting in a great deal of concern for the safety of the entire family.

Child intervention staff determined that it would be best to remove Jack from the home as Ms. Alexander was beyond her capacity to provide him with the care that he required given his challenging behaviors.

Three months after being placed in the Alexander home, which was meant to be his "forever home", seven-year-old Jack was moved to a group home against the advice of the behavioral consultant. The group home was not seen as a permanent placement, rather it was intended to be short term and the hope was that his behavior would stabilize in this structured environment.

This time, there appeared to be little or no planning to the move and the transition did not go well. Jack became very upset when he was moved because he believed Ms. Alexander would be taking him to his new placement and this did not happen. He was so upset that it took the caseworker along with two colleagues to get Jack into her car. However, once in the vehicle, he calmed down and was curious about his new placement. Caseworker Two stayed with him at the group home until he settled.

Services During Jack's Final Days

When he arrived at the group home, Jack appeared to adapt well to his new environment. He did not display any negative behaviors during his first ten days in the home. Group home staff had witnessed some emotional behavior when Ms. Alexander and Jack saw each other at scheduled swimming lessons.¹⁵ They felt this was upsetting and confusing for him and requested that Ms. Alexander distance herself from Jack. Caseworker Two indicated that Jack appeared happy and well-adjusted during her follow-up visit.

On the eleventh day at his placement, a group home staff member took Jack and two other residents to a local public swimming pool. They took the bus from the group home to the pool. Jack changed by himself in the boy's change room, came out and waited for the others on the pool deck. They entered the pool together, but the staff member left Jack, unsupervised, while she took one of the other children out of the pool. Seven minutes later, Jack was found unresponsive near the pool's deep end. He was transported by ambulance to the hospital and pronounced dead a short time after his arrival.

Caseworker Two was notified and attended the hospital.

Approximately, four hours after leaving the hospital, Caseworker Two was contacted by a donation professional¹⁶ requesting that Jack's tissues be donated. There was a "two-hour window" within which a decision had to be made. The caseworker passed

¹⁵ Ms. Alexander's son was enrolled in the same swimming lessons as Jack.

¹⁶ Healthcare worker trained in the legal and ethical aspects of obtaining consent for organ and tissue donation.

the request on to her manager who consulted with senior officials. Ongoing attempts to locate Jack's parents were made with police assistance, but were unsuccessful. The request to donate Jack's tissues was approved by senior child intervention officials within two hours after the request was made.

It took some time to contact Jack's parents and notify them of their son's passing. Child intervention staff were able to speak to Joe the following day; however, it took much longer to locate Mary. Unfortunately, she heard about Jack's death through relatives and contacted the child intervention office some days later.

At the time of Jack's death he had been in the temporary care of the Director for 909 days (approximately two and a half years). The PGO hearing was scheduled to begin two months after his death.

DISCUSSION AND RECOMMENDATIONS

The information gathered through the investigative review process revealed a number of key issues related to practices and processes in the child intervention system:

Supporting key relationships for children in care

Court delays for children in temporary care

Designing and evaluating interventions in a team context

Ensuring lessons regarding placement investigations are learned province-wide

Decision-making after a child in temporary care passes away

Supporting Key Relationships for Children in Care

Young people who come into care must be provided with safe and stable environments while ensuring that significant relationships are supported whenever possible. If a relationship is seen as detrimental or not in the child's best interests then there must be resolution and closure if necessary. Relationships contribute to a young person's sense of belonging and the development of their identity. The *Enhancement Act* emphasizes the benefits of stability and continuity of care and relationships when a child is being placed outside of their family¹⁷.

Children encounter and develop relationships with many individuals as they move through the child intervention system - caregivers, caseworkers, teachers, health providers, peers and foster siblings in addition to their family of origin. They may develop significant connections with any of these individuals, just as they developed unique relationships with members of their own family.

When relationships are terminated children may experience a profound sense of loss and confusion. They may be afraid to develop new relationships for fear that these relationships will also be taken away. Children grieve the cumulative loss of each relationship when they are disrupted.

Jack experienced grief over the loss of his relationships and the way of life he knew before coming into care. While in the care of his parents, Jack lived a transient lifestyle where there was little structure and he didn't know, from day to day if his basic needs, such as food and shelter, would be met. Jack related to his parents as peers or partners.

Upon coming into care, Jack was placed with the Smith foster family where there were seven other family members. There was lots of structure and routine. He had to learn to share the parents' attention. The adjustment to the Smith home was likely very difficult and confusing for Jack. While it might be perceived that coming into care offered him a better life, from Jack's perspective it may not have been his view of a better life.

Jack struggled to understand why he was in care and his role in his foster family. The experience was very likely overwhelming for him and he may not have had the ability to name or express his feelings. Within months of being placed with the Smiths, his foster parents and his teacher reported that he was becoming increasingly angry and prone to tantrums. Although Jack was engaged in play therapy for approximately 15 months, he was not able to deal with his feelings of grief and loss.

During visits with his parents, Jack was routinely subjected to their unfulfilled promises that he would return to their care. This caused Jack a great deal of distress, confusion; and later, anger and sadness. At one point he told Mary, "Well, you know Mom, I've been in care for two years."

¹⁷ *Child, Youth and Family Enhancement Act*, RSA 2000, c. C-12. This is noted in the "Matters to be Considered" in the Act.

After living with the Smiths for 28 months, Jack again experienced the loss of relationships when he transitioned to Ms. Alexander's home. In addition to losing the foster family he had lived with for over two years, play therapy with the mental health therapist ended and a behavioral therapist took her place. Indeed, Jack struggled in the Alexander home and his challenging behaviors ultimately led decision-makers to move him to a group home.

Upon moving to the group home, Jack further experienced relationship losses with Ms. Alexander and her son.

Compounding these losses was Jack's growing distress over the gulf between his parents' promises that he would be returning home, and the reality of his situation. Conversations Jack had with his caseworkers, his foster parents and therapists revealed his frustration with his parents' instability and his desire to live with his father. Such conversations could have been opportunities to clarify with Jack how his mother and father could remain a part of his future despite being raised by another parent.

When undertaking permanency planning, it is critical to "gain the cooperation of the most significant attachment figures available" in a child's life, so that the child is given permission to be part of another family¹⁸. For Jack, the permission to move forward would have ideally come from his parents. As challenging as it may be to involve parents in these conversations with their children, it needs to be attempted.

Placement moves are often inevitable and occur for a number of different reasons. How these transitions occur is important for the health and well-being of a child. Having caregivers work together before, during and after placement transitions provides the opportunity for caregivers to stay connected with a child after a move. It also allows for thorough information-sharing, which is in the child's best interest.

Sudden moves in placement, by contrast, can compound feelings of loss and grief in a child, especially if the move disrupts the child's existing relationships with significant adults in his or her life. This, in turn, can hamper the achievement of permanency for the child.

Jack was seven years old when he left the Smith family to live with Ms. Alexander and her son. He was told about the move three weeks before it happened, and a series of visits occurred. The transition was thoughtfully planned and Jack initially appeared to respond positively. Mr. and Mrs. Smith, Ms. Alexander, and the caseworker worked very collaboratively in the weeks before and after the move.

Jack's final move, to the group home, was different. His placement with Ms. Alexander had broken down. There was a sense of urgency to move him because his behaviors were causing concern for everyone's safety. Despite this, Jack and Ms. Alexander had

¹⁸ Donley, K.S. (1988). Disengagement work: Helping children make new attachments. In H.L. Craig-Oldsen (Ed.), *From foster parent to adoptive parent: A resource guide for workers*. Atlanta, GA: Child Welfare Institute.

formed a relationship. She was committed to staying involved with him during and after his transition from her home. However, Ms. Alexander was not permitted to accompany Jack when he was moved. Rather than regarding Ms. Alexander as a significant person who could support Jack through his move, her involvement was viewed as negative and potentially harmful.

After the move, Ms. Alexander continued to take her son to the same swimming lessons that Jack was attending. This contact was emotional for both her and Jack which resulted in the request that she not approach Jack during lessons. Again, rather than this being viewed as an opportunity for Jack to resolve and maintain a significant relationship it was viewed as a problem.

Caseworkers attempted to locate a family placement for Jack, asking his parents to provide names and contact information for people with whom he might have a relationship. Joe and Mary avoided providing this information for an extended period of time which resulted in Jack being deprived of access to his extended family. Eventually, this proceeded without their consent, but in the meantime Jack suffered the loss of these relationships.

Consistent with a holistic approach to service provision is the need to balance a focus on the child with a focus on the family. In a previous Investigative Review,¹⁹ the Advocate noted the difficulties that can result when intervention services place a focus on supporting parents without placing a similar level of focus on the needs of the child.

By supporting continuity of connections with parents, caregivers and other key individuals in their lives, children are given opportunities for their significant relationships to prevail, despite life's changes and challenges. This is critical to building resiliency in children. This needs to be recognized and practiced when children are brought into care and when transitioning children between placements.

Recommendation #1

The Ministry of Human Services should ensure the preservation or resolution of relationships are at the foundation of permanency planning for children:

- Children need to be involved - at a level appropriate to their understanding - in envisioning how their significant relationships will look in their future. Attention should be given to grief and loss interventions where relationships are lost or ambiguous.
- Transitions between parental care and placements within the system need to be deliberate and focused on a child's need for consistent relationships.

¹⁹ *Remembering Brian*. (2013). Office of the Child and Youth Advocate of Alberta.

Court Delays for Children in Temporary Care

While supporting key relationships through permanency planning for children in care is fundamental, addressing permanency through legislation and legal status is essential. The *Enhancement Act* identifies timelines by which decisions must be made for children in temporary care. The total cumulative time that a child is in the temporary care of the Director shall not exceed nine months for a child under six years of age or 12 months for a child six years or older. There is an allowance for one additional temporary period of up to six months if it is believed that the child can be returned to their guardian within that time or there are "good or sufficient reasons to do so" (*Enhancement Act* section 33). The *Enhancement Act* further states, "there should be no unreasonable delay in making or implementing a decision affecting a child" (Matters To Be Considered, Section 2.o).

Jack had been in care for 237 days (eight months) when a decision was made to apply for a Permanent Guardianship Order, which met the legislative requirements. Jack's parents were not in agreement with the Application resulting in the need to schedule a hearing of three or four consecutive days. Consequently, the PGO hearing was booked approximately seven months after the application was filed. A month before the hearing, a Judicial Dispute Resolution (JDR)²⁰ occurred where it was agreed that the hearing had to be delayed to allow the parents to complete their parenting assessments. The earliest dates that were available were three months later in a courtroom that was already booked. This is a common practice as hearings often do not proceed. However, in this case the other trial went ahead, resulting in Jack's PGO hearing being adjourned for another six months. By this time Jack had been in care for two years.

It was at this hearing where Jack's mother failed to show up and his father fired his lawyer resulting in a further adjournment of six months. Jack passed away two months before the hearing was rescheduled to occur. Jack's cumulative time in care was 909 days when he died.

Considerable energy was expended by caseworkers in coordinating access visits, drug testing and in-home supports for Jack's parents. Despite these efforts, Joe and Mary made limited changes toward having Jack returned to their care, while taking actions (such as firing their lawyer and not attending court dates) that drew out the court process through a succession of adjournments.

In summary, the hearing was postponed three times for a total of 24 months from the time the caseworker applied for the PGO (within the required timelines) until the last hearing was scheduled. Two of the three adjournments were due to delays on the part of the parents.

²⁰ Judicial Dispute Resolution (JDR) meetings are mandatory meetings that involve a Judge with all of the parties in a contested court application. The intent is to reach a resolution between the parties to avoid the more intrusive trial process.

In reviewing Jack's circumstances, the Advocate was discouraged by the court delays and the impact they had on establishing permanency for Jack. Children need to have some degree of certainty and they need to know what the future might hold for them. They must not be left in temporary care.

This situation may not be unique to Jack. It is concerning that the best interests of children appear to be secondary to excessive delays in the court system. Studies in other provinces have also identified court delays as a significant problem for children in care and have led to some reform^{21 22}. This issue must be examined and addressed in Alberta.

Recommendation #2

The Ministry of Human Services in collaboration with the Ministry of Justice and Solicitor General should undertake a review of court delays for children in temporary care:

- identify the number of children for whom court delays have impacted permanency;
- identify the barriers that are causing court delays;
- establish a plan to resolve this issue; and,
- report on progress.

Designing and Evaluating Interventions in a Team Context

One of the themes in current child welfare research is the shift in providing services from a reductionist approach toward a holistic approach²³. A reductionist approach is the tendency for casework to engage key people in isolation from each other. A holistic casework approach brings together those who hold influential relationships in the child's life to understand what is driving the child's behaviors²⁴.

²¹ *White paper on Family Relationship Act Reform*, British Columbia: Ministry of the Attorney General <http://www.ag.gov.bc.ca/legislation/family-relations-act/family-law-act.htm> (2010)

²² *Report of the Access to Family Justice Task Force*, The Maritimes: Ministry of Justice and Consumer Affairs www.gnb.ca/0062/FamilyJustice/FinalReport-e.pdf (2009)

²³ G. Ruch. "Relationship-based practice and reflective practice: holistic approaches to contemporary child care social work." *Child and Family Social Work*. 2005(10), 111-123.

²⁴ E. Thulberg and G.N. Sauve M.D. Trauma Informed Practice with Children and Youth in the Child Welfare System. Webinar on February 6, 2013. National Resource Centre for Permanency and Family Connections, Silberman School of Social Work at Hunter College.

Jack was experiencing grief over the loss of his way of life and his relationships. When viewed through this lens, many of his behaviors are understandable. More could have been done to bring together the key people in his life and make decisions through a holistic approach. Instead, things appear to have been less coordinated. Individuals who had influential relationships with Jack appeared to be acting in silos, and information was not adequately shared. Meetings occurred between the caseworker and the parents, the caseworker and the foster parents, the caseworker and the teacher; and, the caseworker and her supervisor. There were no meetings that brought all the key people together to collectively exchange information and provide input to planning for Jack.

Mr. and Mrs. Smith felt that Jack had difficulties attaching to others. They arranged for a mental health therapist to see him and advised the caseworker afterward. This was a free service at no cost to child intervention services. It is evident that the mental health therapist was not provided with adequate historical information about Jack nor was she actively involved in case planning meetings. The therapist's professional contacts were primarily limited to the Smith's with occasional phone contact with the caseworker and the Smith's foster support worker.

Jack was then referred to a psychiatrist with the anticipation that he would be diagnosed with attachment disorder. The psychiatrist relied primarily on information provided by the Smiths. Again, there was little information provided about Jack's family background prior to being in care. Jack was not diagnosed with attachment disorder; however, it was recommended that he continue to see the mental health therapist to work on his anxiety and social skills.

Shortly after Jack was moved to Ms. Alexander's home, a behavioral consultant became involved to provide Ms. Alexander with strategies to deal with his behaviors. At this point, Jack's long-standing involvement with the mental health therapist was stopped - during a period of critical transition for him. There are conflicting accounts whether the therapist's role was temporarily interrupted or terminated and what the rationale was. There is no evidence that the therapist and the behavioral consultant exchanged information about Jack. The strategies provided by the behavioral consultant appeared to have only a minimal effect on stabilizing Jack.

Had a more holistic approach been taken, the supports and services provided to Jack may have produced better outcomes for him. Without help to deal with his grief and loss, Jack's behavior worsened as he transitioned from placement to placement, further experiencing a layering of losses. Due to his behavior, Jack's last move was to a group home, despite the behavioral consultant cautioning against it. However, the consultant conceded that Jack needed to be moved as Ms. Alexander was unable to manage his behaviors and it was the only placement available.

The Enhancement Act Policy Manual states that caseworkers are responsible for arranging joint case conference meetings "to be held throughout the provision of services to the child and family including at review and decision points, changes in

service circumstances, removal from placement, transfer or closure of file.”²⁵ Key people such as foster parents, birth parents, therapists and teachers can collectively exchange information toward ensuring that planning for the child is current and relevant. Wherever appropriate, the child needs to participate in these meetings.

Recommendation #3

The Ministry of Human Services needs to reinforce compliance to existing policy regarding regular case-conferencing with all stakeholders and service providers, ensuring that children are involved whenever possible.

Ensuring Lessons are Learned Province-wide

In addition to the Advocate's investigative review, there were three independent reviews into Jack's drowning and a number of sound recommendations were made. All of the recommendations are related to enhancing children's well-being, specifically in relation to water safety and supervision. More detail is provided in Appendix 3.

One of those reviews was completed by the Child and Family Services Authority (CFSA) that was responsible for Jack. When concerns are raised about a placement, or when a serious incident occurs regarding a child in care, the service delivery system having jurisdiction over the placement may conduct a placement investigation or review. The purpose is to identify factors that may have contributed to the incident, address the factors and prevent similar incidents from occurring in the future.

The CFSA conducted a review of the contracted agency that operated the group home where Jack was placed at the time of his death. As a result of the review, the CFSA made several recommendations to the agency. These included the implementation of:

- a new recreational policy to increase supervision and responsibility;
- stronger communication strategies to ensure greater awareness of safety procedures; and,
- guidelines for response to critical situations.

The CFSA's review and recommendations were recorded in the Human Services' electronic database system. Copies of the final report of the review were also to be shared with the CFSA's Contracts and Licensing division and other parties involved in this particular matter.

²⁵ *The Enhancement Act Policy Manual*, Section 7.1.1.

Historically, when recommendations have arisen out of a service delivery investigation involving a placement, it was confusing and inconsistent as to where those recommendations were kept in the electronic database. Accounting for how the recommendations are addressed has also been a challenge. Implementation of a new child intervention database in Alberta was completed in the spring of 2013. It remains to be seen if this new system will be applied in a way that addresses these issues.

It is unclear what the Ministry's responsibilities are regarding investigations into placement facilities across the province. There does not appear to be any centralized, formal process in place for analyzing the results of placement investigations and disseminating the lessons and recommendations from those investigations province-wide. This presents a significant opportunity for making system-wide improvements. The results of a placement investigation in one area would no doubt have relevance for other areas of the province. By examining placement investigations; identifying systemic concerns and disseminating lessons learned from them, the Ministry would ensure that all children across the province benefit from any lessons learned.

In relation to Jack's tragic death, consider how many other placement resources across the province take children swimming as a recreational activity; consider how these resources might benefit from knowing the recommendations made by one service delivery system regarding swimming outings. There is a good likelihood that other placement resources in the province would implement similar changes. The result would be a greater number of safer recreational outings for children in care across the province, rather than in a single facility. And, this would contribute to preventing similar incidents from occurring in the future.

Recommendation #4

The results of service delivery placement investigations should be better coordinated to ensure that:

- Recommendations resulting from these investigations are documented and accounted for in the Human Services' electronic database to ensure their resolution;
- Results of placement investigations are centrally analyzed in order to identify key learnings that could enhance the strength of the overall system; and
- The learnings identified from service delivery investigations are actively disseminated province-wide, with the goal of enhancing the safety and well-being of children in care.

Decision-Making after a Child in Temporary Care Passes Away

After Jack passed away, the CFSA gave approval for his tissues to be donated. This decision was made by senior officials. Medical staff had communicated that a decision was required within two hours. Child intervention staff obtained police assistance in attempting to contact Jack's parents so they could notify them of their son's death and consult with them about this request. Unfortunately, all attempts were unsuccessful until the following day when they were able to speak to Jack's father.

Through the Advocate's review, it became apparent that child intervention policy is unclear regarding the decision making authority for children who pass away while in temporary care.

Section 4(2) of the *Human Tissue and Organ Donation Act* provides direction on who may consent to the tissue and organ donation of a minor child. In order of priority, the Act permits a parent or guardian, an adult sibling, or any other adult next of kin to consent on behalf of a minor²⁶.

Section 42 of the *Enhancement Act* provides guidance in the event that a child in care passes away. In situations where the child is the subject of a TGO, the Act states that "the Director may arrange for the burial or other disposition of the body if the Director is unable, after making reasonable efforts, to locate the other guardian of the child within a reasonable time." The Act does not elaborate on what constitutes reasonable efforts, or reasonable time. Nor does it specify what "disposition of the body" entails.

Section 7.2.2 of the *Enhancement Act Policy Manual* further outlines the procedures to follow when a child in care dies. If the child is the subject of a TGO, the Director is responsible for addressing the child's funeral and burial arrangements. This policy is consistent with the authority given to the Director under legislation.

In relation to requests for tissue and organ donation, policy states, "refer the hospital to the guardians." Under a TGO, the Director shares guardianship with the parent/legal guardian, and in practice the Director is given more weight in decision-making. The Advocate, through the investigative review, was unable to find this in policy. Unfortunately, as the policy is currently written, child intervention staff do not have clear direction about their decision-making authority when a child in temporary care passes away. This is especially concerning as it is an emotionally-charged and grief-laden time.

Child intervention staff attempted to contact Jack's parents to consult with them about this difficult ethical decision but they could not be located. Intervention staff reviewed the information that they had about the family and found that there was no religious or

²⁶ *Human Tissue and Organ Donation Act* SA 2006, c H-14.5

cultural information that might provide guidance regarding his parent's wishes. Then, in his parents' absence, senior intervention officials consented to the tissue donation. In the absence of clear policy direction, legislative authority or family guidance, the basis for consent to donate tissues was questionable.

This raises another question - what are parents told when their children are brought into the care of the government, specifically in relation to decision-making? Are they aware, that when they cannot be located decisions may be made about their child that they may not agree with? Through this review, these questions could not be answered.

Recommendation #5:

The Ministry of Human Services should:

- (A) Review, clarify and communicate policy regarding the decision-making authority of the Director when a child in temporary care passes away. Including clear policy direction for decisions related to tissue donation.
- (B) The Ministry of Human Services should review case practice in relation to what parents are told when their child is in temporary care; specifically, the decision-making that might occur in the parents' absence. Policy should be implemented to ensure consistent application across the province.

CLOSING REMARKS FROM THE ADVOCATE

Jack was seven years old when he died as a result of a drowning accident. It is such a tragedy to lose someone so young. My heart felt sympathies are extended to his family and others who knew him.

Reviews by three of the organizations involved in this tragedy have identified changes to improve the safety and reduce the risks for children involved with activities like swimming in pools. If fully implemented, these changes will result in children being safer when engaged in these activities.

The Investigative Review completed by my office considered the circumstances of Jack's life and his care within the child intervention system. The findings in this Investigative Review need to be considered and the recommendations need be acted upon. Children involved with the child intervention system in Alberta will benefit from implementing these recommendations.

I want to thank all those who contributed to this report. It is reassuring to me that people gave their time, their experience, and their information to help us learn about Jack. There is no question that in his short life, he touched the lives of many.

It is my hope that the findings and recommendations in this review will touch the lives of other children in care and make life a little easier for them than it was for Jack.

[Original signed by Del Graff]

Del Graff

Child and Youth Advocate

APPENDIX 1: TERMS OF REFERENCE INVESTIGATIVE REVIEW – JACK

Date of Incident

2012

Incident

7-year-old Jack was discovered unresponsive in a public swimming pool. He was transported to hospital where he was later pronounced dead. At the time of the incident he was subject of a Temporary Guardianship Order and was placed in a group home.

The decision to conduct an investigation was made by Del Graff, Child and Youth Advocate in November, 2012.

Issues for Investigation

- **Permanency/Transition Planning** - What was the permanency plan for Jack? How was Jack supported through each move and what were the implications?
- **Relationships** - Ongoing contact with individuals with whom he had significant relationships?
- **Therapeutic intervention** - What supports and services were provided to Jack and his caregivers for on-going mental health concerns and behaviors?
- **Placement** - How are issues/concerns identified and addressed for contracted resources?
- **Consent for organ donation** - Under what authority did Child and Family Services employees act to provide consent for Jack's organs to be donated?

Scope of the Investigation

The investigation will examine:

- The assessment process used in determining a permanency plan for a child;
- The coordination and identification of services;
- The ongoing monitoring, services and supports provided to the child, family and caregivers;
- The monitoring of contracted resources; and
- The child intervention standards and any other procedural obligations.

Method

The investigation will be conducted through:

- A review of the electronic and paper files;
- Interviews with CFSA staff and other relevant service providers as required;
- A review of best practices
- Consultation with an expert in permanency planning.

Investigation Plan

A detailed investigation plan will be developed detailing the steps that will be taken, the individuals who are to be interviewed, additional documents that will be requested and reviewed; and, the questions/issues that will be explored.

Review Board (proposed)

Chair

- Del Graff, Child and Youth Advocate

Members (to be determined but may include):

- An expert in the area of in care placements
- An expert in the area of child mental health
- A representative from the Alberta College of Social Workers (ACSW) with experience/expertise in the area of child welfare and best practice

Team

- Lead investigator, Office of the Child and Youth Advocate
- Investigator, Office of the Child and Youth Advocate

Reporting

The Child and Youth Advocate will release a report when the investigation has been completed.

APPENDIX 2: COMMITTEE MEMBERSHIP

Del Graff, MSW, RSW (Committee Chair)

Del is the Child and Youth Advocate for the Province of Alberta. He has worked in a variety of social work, supervisory and management capacities in communities in British Columbia and Alberta. He brings experience in residential care, family support, child welfare, youth and family services, community development, addictions treatment and prevention services. He has demonstrated leadership in moving forward organizational development initiatives to improve service results for children, youth and families

Robert G. Lewis. M.Ed., M.S.W., L.I.C.S.W.

Bob Lewis provides consultation (at the casework, supervisory, and systems levels), training, and public speaking to child welfare organizations with a focus on permanence for every child, policy, and practice development. Based in Massachusetts and North Carolina, he is active throughout the US and internationally (Canada and Japan). He coauthored *Adolescents & Families For Life: A Toolkit for Supervisors®* as Executive Director of Special Adoption Family Services (SAFS) and later, he developed and edited the *Family Bound Program* curriculum (2002) which prepares adolescents for permanency. His most recent book, also co-authored with Ms. Heffernan, borrowed the name of the New York City initiative in which he was involved, *Families for Teens*. He has also authored or co-authored several other articles concerning adoption and permanency. Bob's sharpest focus is on the youth most likely to age out of foster care. He recently developed a tool for those who work with youth: *Seeing the Voices of Children and Youth: Setting the Record Straight (The Video Project)*.

From 1978 to 1998, he was the Executive Director of SAFS (Project IMPACT) in Boston, a pioneer agency in the development of special needs adoption practice. He is a Board Member At-Large of the national Family Builders Adoption Network, formerly a Steering Committee member of the Youth At Risk initiative of the Essex County Community Foundation, and he participates in several other child welfare practice and advocacy groups. He holds Master's degrees in Social Work and Education.

Brendan Leier, PhD

Dr. Brendan Leier earned his PhD from the University of Alberta in 2002. He is currently the Clinical Ethicist at the University of Alberta and Stollery Children's Hospital and the Mazankowski Alberta Heart Institute, and Clinical Assistant Professor in the Faculty of Medicine and Dentistry at the University of Alberta. Dr. Leier is presently doing research on the topics of pediatric best interest, moral distress, end-of-life decision-making, transplant ethics, ethics of medical technology, compassion in the practice of medicine, risk and decision-making.

Peter Choate, PhD, RSW

Dr. Peter Choate is an Assistant Professor of Social Work at Mount Royal University. He is an expert witness in the area of parenting capacity (including risk, domestic violence, and addictions). He has been qualified on multiple occasions in the Provincial Court of Alberta (Edmonton, Calgary, and Red Deer) and the Court of Queen's Bench (Calgary and Medicine Hat). He teaches and writes about parenting capacity at workshops, conferences and as a professional development instructor at the University of Calgary.

APPENDIX 3: OTHER REVIEWS

In addition to the Advocate's review, there were three separate independent reviews into this tragedy. One completed by the contracted agency who operated the group home; the second completed by the CFSA responsible for the contracted agency; and, the third completed by the municipality responsible for the leisure centre.

All three reviews recommended changes to some administrative function, structure, policy, or strategy focusing on improving accountability, safety practices, standards, prevention, and awareness.

The contracted agency recommended:

- Administrative changes to the structure and policy for group home staff accountability and development that included:
 - Continued implementation of a "Team Lead Model".
 - Improved communication through the implementation of sign-off on all changes to policy and procedure.
- Revised policy regarding transportation and recreational outings that included:
 - The development of a safety plan for community outings.
 - The submission of outing plans to management for approval.
 - Outings must be based on the child's developmental/cognitive abilities.
 - Staff ratios for swimming outings were modified
 - One staff member to two residents (previously one staff to three residents).
 - Staff members who accompany children on swimming trips must be trained in water safety procedures with a minimum of a current Bronze Medallion and emergency first aid.
 - Life jackets must be used at all times for children under the age of eight, and for children that are unable to swim 25 meters on their own.
 - Children eight years of age and under, or older with cognitive/developmental delays will use the family change room with a staff member.
 - Staff supervision must continue at all times.
 - The CFSA recommended that the contracted agency:
- Implement a new recreational policy to increase supervision and responsibility which included:
 - Gender pairing for residents and staff is considered.
 - A two staff to five resident ratio for community outings.
 - Implement changes to draft swimming policy.

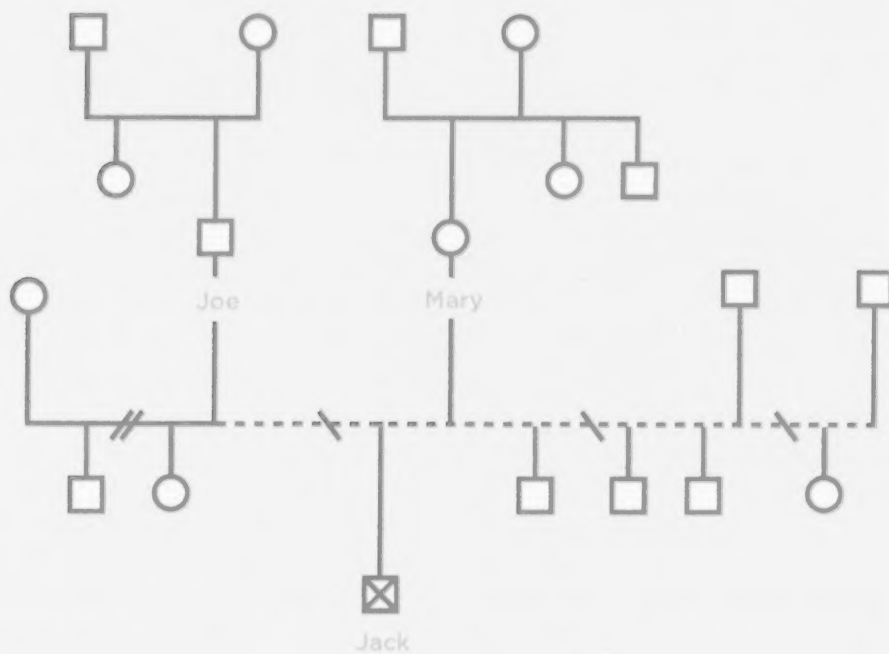
- Implement stronger communication strategies between staff and the administrative team which included:
 - The development of a sign-off process for staff members to acknowledge written methods of communication.
 - The development of adequate communication processes to ensure that staff members are aware of supervision responsibilities.
 - The development of increased communication processes between staff and administration prior to community outings.
- Implement performance management and employee development strategies which included:
 - Staff evaluations should occur at timed intervals of employment.
 - Development of staff job descriptions and responsibilities.
 - Development of processes for staff to acknowledge that they are familiar with their performance objectives and indicators during regular evaluations.
 - Recommendations for staff training and development through the performance management process.
- Develop guidelines for response to critical situations which included:
 - Ensuring residents have timely access to identified supports after a critical incident.
 - Prepare and facilitate a discussion with other agencies at inter-agency meetings to share learnings from the incident.

The municipality review led to a number of specific actions intended to increase safety and water safety awareness at their aquatic facilities.

- Conducted an extensive review of their emergency response to the incident resulting in:
 - The reinforcement of critical incident response policies and practices.
 - The implementation of new staffing ratios and practices.
 - Facility enhancements at the aquatic facility.
- Engaged a third party to conduct an incident analysis:
 - Contracted with the Lifesaving Society to review the incident and provide recommendations.
 - Accepted and implemented all of the Society's recommendations.
- Conducted an internal best practice review of aquatic trends, research, and approaches of other facilities in Canada and the United States.

APPENDIX 4: GENOGRAM

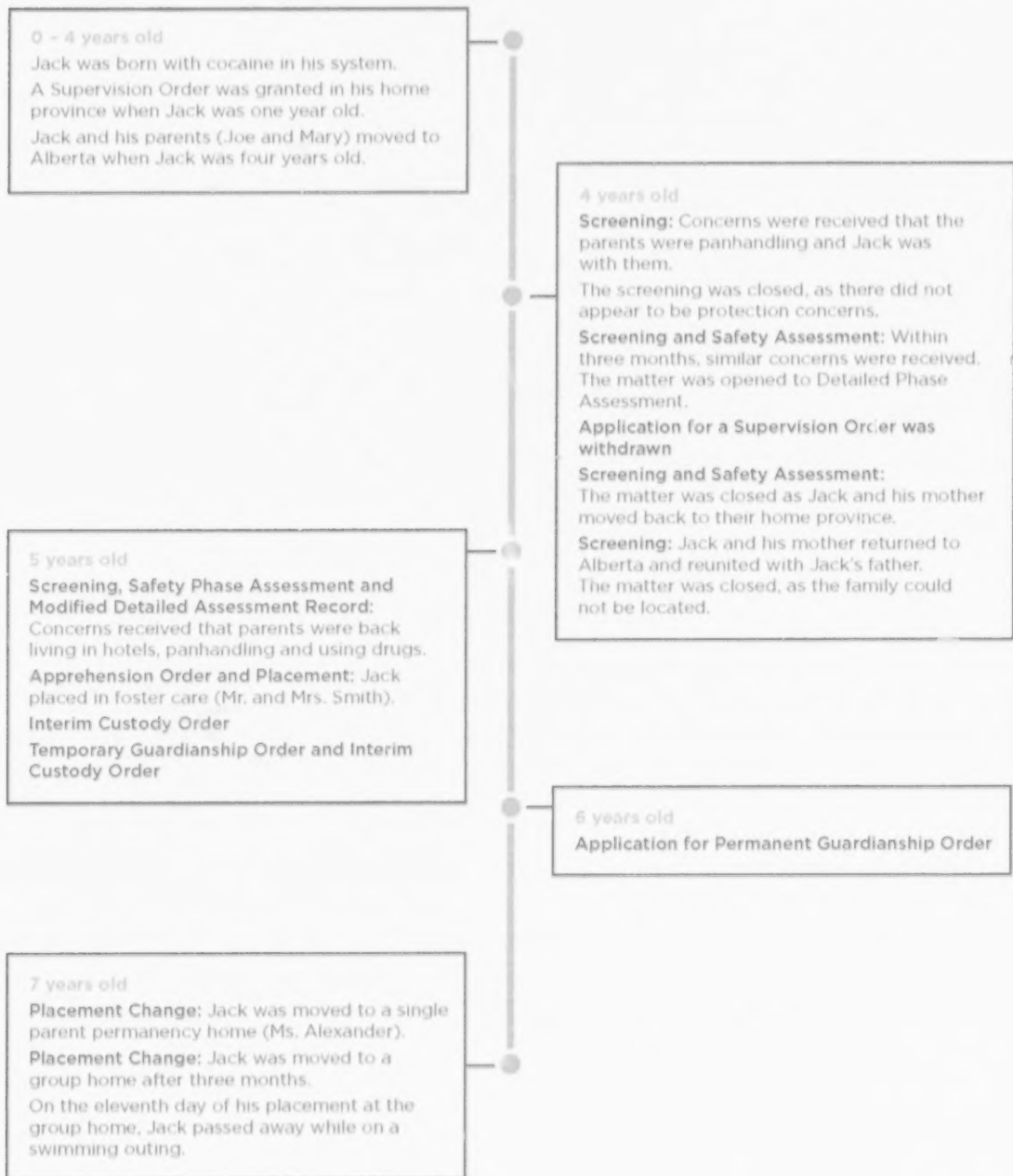
Family Genogram - Jack



Legend

Male	Female	Death	Divorce	Legal cohabitation and separation in fact

APPENDIX 5: SUMMARY OF EVENTS



APPENDIX 6: REFERENCES AND BIBLIOGRAPHY

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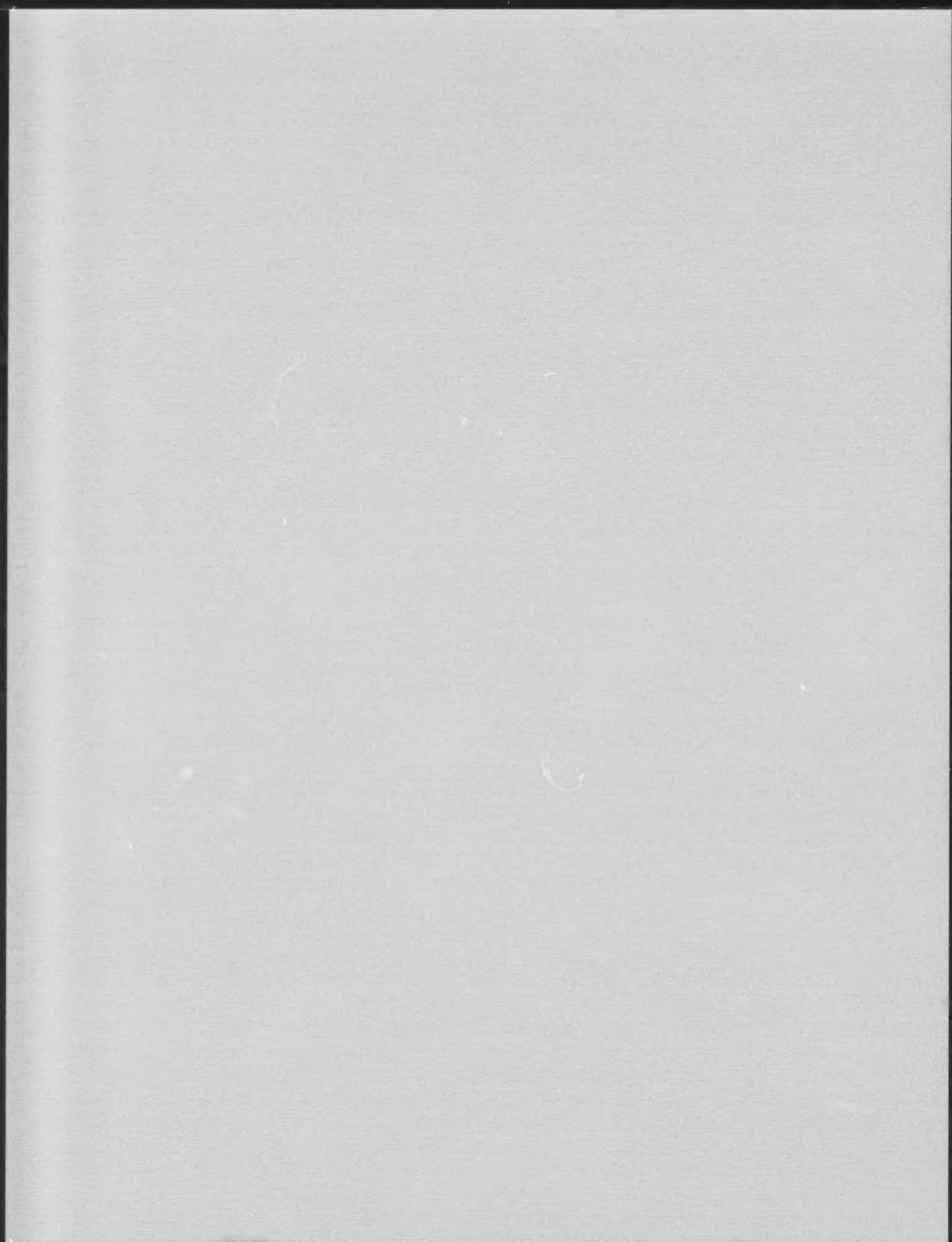
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7-YEAR-OLD JACK: INVESTIGATIVE REVIEW

